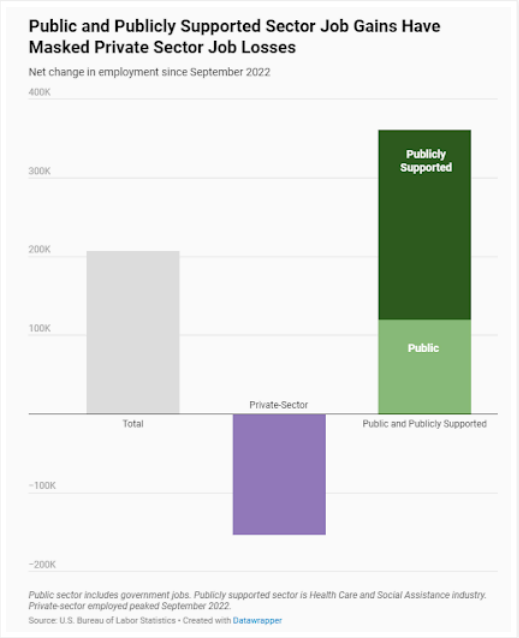
UCLA Faculty Association

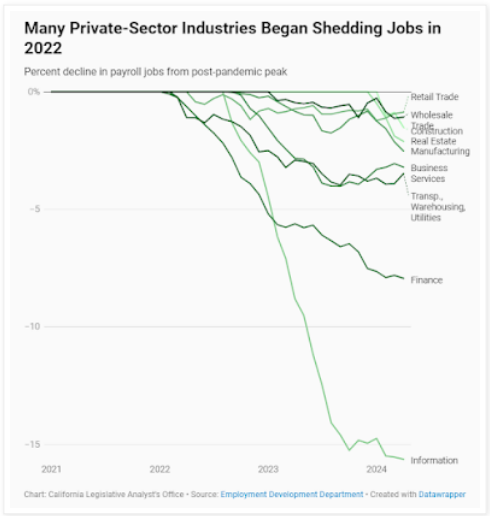
News and opinion from Dan Mitchell since 2009

Friday, July 12, 2024

Underlying Weakness: Not Great for Budget Outlook



In a recent report, the Legislative Analyst's Office (LAO) notes that the California economy has been bifurcated with job losses in private employment offset by gains in public sector jobs (government, health care, and social assistance). The layoffs in the tech sector have been well publicized and show up under "information" in the chart below. But other private industries are also exhibiting job losses. All of this is not good news for the state budget outlook.



Full LAO report at https://lao.ca.gov/LAOEconTax/Article/Detail/806.

Posted by California Policy Issues at 3:00 AM No comments:

Labels: LAO, State Budget

Thursday, July 11, 2024

The Council of UC Faculty Associations

- Faculty File Historic Academic Freedom Unfair Labor Practice Charges Against UC
- Union Letter to UC with Benefits Demands
- We Oppose Deprofessionalizing Librarians
- We Oppose AB-1418's Inadequate Protection from the Harms of Facial Recognition Tech
- We Oppose SB-1287's Restrictions on Protected Speech

Remaking the University

- The Authoritarian Personality Comes to College - 5/2/2024
- The New McCarthyism Intensifies - 4/30/2024
- THE STRIKE - 12/6/2022

Higher Ed. News & Commentary

- Chronicle of Higher Education
- Inside Higher Education
- Remaking the University
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- California Professor

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- UCSB Faculty Association
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Other Faculty Organizations

- American Association of University Professors
- California Faculty Association (NEA)
- UC-AFT

Topics

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Not exactly a buried lede, but...

You have probably read about a recent sexual assault in a UCLA dorm room. At the end of the LA Times article describing the resulting arrest, we read this:

...UCLA has had more sexual assaults reported than any other school in the 10-campus University of California system — 36 between April 2023 and March 2024. Overall, 1,975 crimes were reported at UCLA during that period — larceny and theft being the largest category, with 441 reports, UC systemwide data show. The vast majority of arrests involved suspects who were not affiliated with the university of about 46,680 students.

UC Berkeley, the system's second-largest university, with about 45,700 students, had 14 reports of sexual assaults among 2,222 crimes reported between April 2023 and March 2024. Larceny, theft and motor vehicle theft were the largest issues there, accounting for 1,000 reported crimes; most suspects also were not affiliated with the campus.

UC Santa Barbara had 18 reports of sexual assault, UC Davis 14 and UC Irvine 13 between April 2023 and March 2024. Nine were reported in that period at UC Santa Cruz, seven at UC Riverside, six at UC San Diego, and five each at UC Merced and UC San Francisco.

Full story at https://www.latimes.com/california/story/2024-07-06/suspect-in-custody-after-ucla-student-sexually-assaulted-in-dorm.

Posted by California Policy Issues at 3:30 AM No comments:

Labels: UCLA

Newsom's Activities

A reminder that we preserve recordings of Gov. Newsom's statements on social media on a quarterly basis, along with related videos.

You can find the second quarter of 2024 (April, May, June) at the link below:

https://archive.org/details/newsom-4-3-24-snow-survey.

Given political developments of recent months, the governor is heavily into his not-running-for-president campaign. But as blog readers will know, there are also problems regarding the state budget that have become more pressing.

Posted by California Policy Issues at 3:00 AM No comments:

Labels: governor, politics, State Budget

Wednesday, July 10, 2024

Berkeley Arson (again)

From SFGATE: *University of California, Berkeley police are investigating a possible arson that occurred within campus grounds Monday afternoon. A fire ignited at 4:19 p.m. on top of the Golden Bear Cafe located at 2 Sather Road near the campus's central Sproul Plaza. Police said crews quickly extinguished the blaze and reported "minimal damage" to the structure.*

Police said the fire was a result of arson and was "malicious and intentional." The cafe sits on the eastern end of Cesar E. Chavez Student Center, which was built in 1960 and houses several student services, including the campus program for disabled students.

Monday's fire comes just three weeks after authorities arrested Oakland resident Casey Goonan, 34, for allegedly orchestrating "the firebombing attack of a UC Berkeley Police Department vehicle and three other arson attacks" on campus in June, according to Cal Fire.

Source: https://www.sfgate.com/news/bayarea/article/police-investigating-another-suspected-arson-on-19562290.php.

Posted by California Policy Issues at 3:30 AM No comments:

Labels: UC-Berkeley

Medicare Advantage Scrutiny Continues - Part 2

(205) UC-Irvine (173) fund raising (157) UC-Santa Barbara (141) UC-Santa Cruz (141) UC-San Francisco (133) ballot propositions (132) faculty center (132) controller (131) UC-Riverside (127) CalPERS (120) Master Plan (100) UC-Merced (100) faculty pay (100) Yudof (89) UCRS retirement (60) parking (59) privatization (59) Faculty Association at UCLA (56) CalSTRS (50) UC Berkeley (33) campus climate survey (28) copyright (26) UCRS (21) Michigan Model (18) UC Merced (17) uc funding (16) State Contribution (14) UCOF (14) Regents (13) faculty recruitment (12) UC pay (7) graduate education (6) UC San Diego (5) UCpolitics (3) teaching evaluation (3) UC Irvine (2) UC Santa Cruz (2)

Blog Archive

We have been covering the issue of federal overpayment to Medicare Advantage plans which explains why such plans have been relatively cheap for employers and the expansion of such plans to the point that over half of Medicare participants are under these privatized progrrams.*

As blog readers will recall, at one point UC wanted to substitute Medicare Advantage for other forms of traditional Medicare wraparound plans offered to retirees. After protests, Medicare Advantage was offered as a low-cost option rather than as a substitute. Now the Wall Street Journal has done a study which estimates overpayments by the feds of $50 billion over a 3-year period. (See below.)

It will be hard for Congress and the administration to ignore these findings. Ultimately, the consequence is likely to be some cutbacks in offerings and higher costs to employers - including UC. Perhaps, there might even be a thank-you to those who protested the thwarted move to Medicare Advantage-only, although don't hold your breath on that one. But, for the record, here is UCLA Emeriti Assn. president Richard Weiss on this issue.

Or direct to https://www.youtube.com/watch?v=SXnNt4MwztY.

Insurers Pocketed $50 Billion From Medicare for Diseases No Doctor Treated
Questionable diagnoses of HIV and other maladies triggered extra Medicare Advantage payments; 'It's anatomically impossible'
By Christopher Weaver, Tom McGinty, Anna Wilde Mathews and Mark Maremont
July 7, 2024 Wall St Journal
https://www.wsj.com/health/healthcare/medicare-health-insurance-diagnosis-payments-b4d99a5d [Graphics in original]

Gloria Lee was perplexed when the phone calls started coming in from a representative of her Medicare insurer. Could a nurse stop by her Boston home to give her a quick checkup? It was a helpful perk. No cost. In fact, she'd get a $50 gift card.
After several such calls in 2022, Lee agreed. A nurse showed up, checked her over, asked her questions, then diagnosed her with diabetic cataracts.
The finding was good news for Lee's insurer, a unit of UnitedHealth Group UNH -0.38%decrease; red down pointing triangle. Medicare pays insurers more for sicker patients. In the case of someone like Lee with diabetic cataracts, up to about $2,700 more a year at that time.
But the retired accountant doesn't have diabetes, her own doctor later said, let alone the cloudy vision sometimes caused by the disease.
Private insurers involved in the government's Medicare Advantage program made hundreds of thousands of questionable diagnoses that triggered extra taxpayer-funded payments from 2018 to 2021, including outright wrong ones like Lee's, a Wall Street Journal analysis of billions of Medicare records found.
The questionable diagnoses included some for potentially deadly illnesses, such as AIDS, for which patients received no subsequent care, and for conditions people couldn't possibly have, the analysis showed. Often, neither the patients nor their doctors had any idea.
Medicare Advantage, the $450-billion-a-year system in which private insurers oversee Medicare benefits, grew out of the idea that the private sector could provide healthcare more economically. It has swelled over the last two decades to cover more than half of the 67 million seniors and disabled people on Medicare.
Instead of saving taxpayers money, Medicare Advantage has added tens of billions of dollars in costs, researchers and some government officials have said. One reason is that insurers can add diagnoses to ones that patients' own doctors submit. Medicare gave insurers that option so they could catch conditions that doctors neglected to record. The Journal's analysis, however, found many diagnoses were added for which patients received no treatment, or that contradicted their doctors' views.
The insurers make new diagnoses after reviewing medical charts, sometimes using artificial intelligence, and sending nurses to visit patients in their homes. They pay doctors for access to patient records, and reward patients who agree to home visits with gift cards and other financial benefits.
Insurers added diabetic cataract diagnoses to 148 patients treated by Dr. Howard Chen, an ophthalmologist in Goodyear, Ariz. He said he saw at most one or two such cases a year.
He said he charges insurers $40 per patient to cover his costs for providing them with medical charts.
"If they are just making stuff up, then why do they even need or want my charts?" said Chen.
In all, Medicare paid insurers about $50 billion for diagnoses added just by insurers in the three years ending in 2021, the Journal's analysis showed.

Contributors

- California Policy Issues
- Toby Higbie
- UCLA Faculty Association

How Medicare pays insurers

The government pays insurers a base rate for each Medicare Advantage member. The insurers are entitled to extra money when their patients are diagnosed with certain conditions that are costly to treat.

Like morbid obesity.

That gives insurers an incentive to search for additional diagnoses. The result is that many of their patients seem sicker, at least on paper.

Medicare pays nothing for some diagnoses.

But insurers can add ones that do pay, even if a patient's treating doctor doesn't agree.

Diabetic cataracts are a complication of diabetes that occur when uncontrolled blood sugar damages the lens of the eye, clouding a person's vision.

UnitedHealth members were about 15 times as likely to have that diagnosis as the average patient in traditional Medicare, the Journal analysis found. Eye doctors interviewed by the Journal said it was implausible that such a large share of UnitedHealth's patients could have the relatively rare disease.

The government paid all Medicare Advantage insurers more than $700 million from 2019 to 2021 for diabetic cataracts. Most of the diagnoses were added by insurers.

Medicare Advantage insurers diagnosed all sorts of diseases at high rates.

UnitedHealth and other insurers say they use the home visits and chart reviews to help coordinate patients' care and ensure accurate diagnoses.

UnitedHealth spokesman Matthew Wiggin said the Journal's analysis is "inaccurate and biased," and that Medicare Advantage "provides better health outcomes and more affordable healthcare for millions of seniors" than traditional Medicare.

He said Medicare Advantage plans record diagnoses more completely than doctors treating traditional Medicare patients, and that insurers "identify disease states earlier." He declined to comment about Lee, citing a healthcare privacy law.

The Journal consulted more than a dozen experts, including academics, actuaries and policy analysts, about its analysis of the Medicare data, who said the methodology was sound.

A spokeswoman for the Centers for Medicare and Medicaid Services, which oversees Medicare, said the agency was making changes that would continue to ensure "taxpayer dollars are appropriately spent." Medicare Advantage "offers robust and stable options" for beneficiaries, the spokeswoman said.

HOW THE JOURNAL ANALYZED MEDICARE DATA

The Journal reviewed the Medicare data under a research agreement with the federal government. The data doesn't include patients' names, but covers details of doctor visits, hospital stays, prescriptions and other care. The Journal identified the patients named in this article through their doctors.

Some diagnoses claimed by insurers were demonstrably false, the Journal found, because the conditions already had been cured. More than 66,000 Medicare Advantage patients were diagnosed with diabetic cataracts even though they already had gotten cataract surgery, which replaces the damaged lens of an eye with a plastic insert.

"It's anatomically impossible," said Dr. Hogan Knox, an eye specialist at University of Alabama at Birmingham. "Once a lens is removed, the cataract never comes back."

Another 36,000 diabetic cataract patients didn't receive any medical services or prescription drugs related to diabetes.

No treatment

About 18,000 Medicare Advantage recipients had insurer-driven diagnoses of HIV, the virus that causes AIDS, but weren't receiving treatment for the virus from doctors, between 2018 and 2021, the data showed. Each HIV diagnosis generates about $3,000 a year in added payments to insurers.

Everyone with HIV should be on antiretroviral drugs, the only effective treatment, and nearly all Medicare patients whose doctors diagnosed the virus took the drugs. Less than 17% of patients with insurer-driven HIV diagnoses were on them, the Journal found.

"It seems like almost all of those people don't have HIV," said Jennifer Kates, HIV policy director at KFF, a health-research nonprofit. "If they did, that would be substandard care at a pretty severe level," she said.

Treatment Gap

Patients diagnosed with various conditions by Medicare Advantage insurers received typical treatments for their conditions at lower rates than those diagnosed by doctors.

A spokesman for Humana, the second biggest Medicare Advantage insurer, provided a written statement that said the Journal's analysis of treatment rates for people with insurer-driven diagnoses "is flawed and misleading."

The company said that internal data showed its HIV patients who got diagnosed in one way, through home visits, were on antiretroviral treatment at a far higher rate than the Journal found.

The Medicare data show about one-third of those Humana patients were on the drugs.

Wiggin, the UnitedHealth spokesman, called the Journal's analysis flawed because it correlates insurer-driven diagnoses with subsequent medical care.

He said internal company data for 2022 showed a treatment rate for patients UnitedHealth diagnosed with HIV of more than triple what the Journal found. He said the pandemic disrupted care, lowering treatment rates during the period analyzed by the Journal, and that the analysis failed to account for patients who started treatments in future years.

The Medicare data, however, show UnitedHealth's patients with insurer-driven HIV diagnoses were on the antiretrovirals at low rates even before the pandemic, and hardly any started the drugs in the years after UnitedHealth diagnosed them.

UnitedHealth's HIV Treatment Rate

The insurer diagnosed 1,285 patients with HIV in 2018. Most stayed in Medicare Advantage through 2021, but few received recommended HIV treatments.

Some of the insurer-driven diagnoses startled patients. Harriet Siskin, a retired customer-service worker, was diagnosed last year with obstructed arteries in her legs by a doctor who visited her house on behalf of her insurer, Humana, which stood to make an extra roughly $2,300 a year from the diagnosis.

"He told me that I may have some sort of artery blockage," said Siskin, who tested negative a few months later after her regular doctor ordered a full work-up. "He did scare me."

Humana's written statement said Siskin's primary-care doctor also submitted the diagnosis when he treated her following the home visit. It said Humana learned from the Journal that Ms. Siskin had later tested negative for the disease, and was working to correct the diagnosis.
"[W]e strive for complete and accurate clinical information about our members, and to help them get the care they need," Humana said.
Many patients may never know they have been misdiagnosed by their insurers, and doctors often don't know when insurers have added diagnoses of their patients.
Insurer-driven diagnoses by UnitedHealth for diseases that no doctor treated generated $8.7 billion in 2021 payments to the company, the Journal's analysis showed. UnitedHealth's net income that year was about $17 billion.

Sick Pay
UnitedHealth's Wiggin said the Journal's calculations appear accurate. He said the added payments are "not simply earnings for the company," but help pay for medical care, lower premiums and provide other benefits for Medicare Advantage members.
Humana disputed the Journal's calculation that the company had received $2.2 billion in 2021 payments from insurer-driven diagnoses, saying that total didn't reflect chart reviews that lowered payments by removing diagnoses.
Sometimes, insurers didn't remove potentially outdated diagnoses. The Journal's analysis found that between 2018 and 2021, nearly 50,000 Medicare Advantage patients completed a course of high-cost drugs that almost always cures hepatitis C, a virus that can cause serious liver damage.
Insurers subsequently told Medicare that more than half of the patients who had received the drug treatment still had hepatitis C in a future year, leading to millions of dollars in extra payments. The diagnoses came from the insurers' chart reviews and assessments, and from physician claims that insurers didn't correct.
"They're totally wrong," said Douglas Dieterich, director of the Institute for Liver Medicine at Mount Sinai Health System in New York. "Real world evidence is a 99% cure rate."

Cost concerns
When Congress conceived of the Medicare Advantage program decades ago, the hope was that insurers would make Medicare more efficient. In traditional Medicare, doctors and hospitals get paid for each service they provide, an incentive to provide more. The idea behind Medicare Advantage was to pay private insurers a lump sum to cover all services, giving them an incentive to keep patients healthier.
To protect insurers from the risk of winding up with sicker-than-average patients, the government allowed bigger payments for certain serious health conditions.
Partly because of that, Medicare Advantage has cost the government an extra $591 billion over the past 18 years, compared with what Medicare would have cost without the help of the private plans, according to a March report by the Medicare Payment Advisory Commission, or MedPAC, a nonpartisan agency that advises Congress. Adjusted for inflation, that amounts to $4,300 per U.S. tax filer.
Academic researchers and government investigators have raised questions about high rates of insurer-driven diagnoses in Medicare Advantage. In a 2021 report, the inspector general that oversees Medicare found the agency spent billions of dollars based on insurer-driven diagnoses for which patients received no care from doctors.
A 2019 whistleblower lawsuit by a Florida doctor alleged that an insurer submitted inaccurate diagnoses, including that a Medicare Advantage patient's foot had been amputated when it wasn't. The insurer, Freedom Health, denied the allegations, and a spokeswoman for Elevance Health, which now owns Freedom, declined to comment.
In September, insurer Cigna Group agreed to pay $172 million to settle civil-fraud allegations by the Justice Department over its Medicare Advantage practices. Cigna admitted to adding diagnoses that weren't supported by patients' medical records. Cigna declined to comment.
Government contractors audit Medicare Advantage plans and eventually can recoup payouts for inaccurate diagnoses. An insurance industry trade group, AHIP, said in a written statement that such audits have found Medicare Advantage insurers to be highly accurate.
Medicare administrators are overhauling the list of diseases for which insurers earn higher payments. Some of the most heavily used diagnoses, including diabetic cataracts, will pay less or nothing extra after the changes take full effect in 2026. But new diagnoses, including asthma, were added to the list of conditions warranting extra payments.
CMS said its changes showed it is a "good steward of taxpayer dollars."
John Gorman, a former Medicare official and founder of two companies that review records and conduct home visits on behalf of Medicare insurers, doesn't think the changes will solve the problem. "Any time you base a system like this on diagnosis codes, there's going to be rampant abuse of the system," he said. Insurers "will find something else to make up the revenue."
In 2019, Medicare added dementia to the list of diseases that pay more. That same year, the reported rate of the disease among Medicare Advantage members jumped 7.8% after holding flat for years before that, University of Southern California researchers found.

Vision problems
Cataracts are extremely common in the elderly—pretty much everyone gets them. Diabetes also is common, so it isn't unusual for old people to have both. But eye doctors say they rarely diagnose cataracts caused by diabetes in old people. It usually isn't possible to pinpoint the cause, and in any case, the treatment is the same.
For Medicare Advantage insurers, a big difference between the two forms of cataracts is that the government only pays extra for the diabetic ones.
Some insurers interpreted U.S. guidelines for recording diagnoses in the broadest possible way, labeling patients with diabetes and any kind of cataract with the more lucrative diagnosis. They did it even when doctors said the patients only had the old-age form of the disease or had no diabetic complications at all, the data show.
"If you suspected that it could be connected, they felt they would be justified in connecting it," said Shannon Decker, a former UnitedHealth employee. "It's an easy capture."
UnitedHealth didn't respond to written questions about its practices for recording diabetic cataract cases.
Over four years, insurers added diabetic-cataract diagnoses to 112 patients of Dr. Stephen McConnell, an ophthalmologist in Brunswick, Ga., the data show. "That's unbelievable," said McConnell, who said he had no idea what was happening until informed by the Journal.

Dr. Javier Pérez, an Orlando, Fla.-based eye surgeon, treated hundreds of patients who insurers claimed have diabetic cataracts, the Medicare data show. On average, they were the same age as his old-age cataract patients, about 72.
"Just because you're diabetic doesn't mean you have a diabetic cataract," he said, adding that most almost certainly have old-age cataracts, not ones caused by diabetes. "You can be diabetic and be old," he said.
Lee, the 70-year-old retired accountant from Boston, recalled that her visit with the nurse practitioner sent by UnitedHealth lasted about 20 minutes. The nurse worked for HouseCalls, a unit of UnitedHealth.
UnitedHealth said that in 2023 three million "gaps in care" were identified during such home visits, which typically last 45 to 60 minutes. It said HouseCalls workers called ambulances 624 times that year after identifying emergencies, and that the visits had a 99% customer-satisfaction rate.
Former employees said UnitedHealth also uses the visits to add diagnoses. A HouseCalls home-visit training manual, which was reviewed by the Journal, describes software used on the laptops that workers carry on home visits. According to the manual, the software offers suggestions about what illness a patient might have—and even adds some automatically to a "diagnosis cart."
The nurse visiting Lee concluded that her minor cataracts were caused by diabetes that was severe enough to have triggered nerve damage, according to a letter from HouseCalls to her primary care doctor that was reviewed by the Journal. A diabetes test done during the visit was negative, according to the letter.
Lee's doctor, Nancy Keating, also a professor at Harvard Medical School, said her patient has never had diabetes, let alone complications like diabetic cataracts or nerve damage—a conclusion confirmed by subsequent blood tests.
"It's all just so wrong," Keating said.
Lee agrees. "If they're going to come out and diagnose people with things they don't have, they shouldn't get any more money," she said.
Lee switched to another health plan this year.
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How the Journal Analyzed Medicare Advantage Data
By Christopher Weaver and Tom McGinty
July 7, 2024 Wall St Journal
https://www.wsj.com/health/healthcare/medicare-advantage-data-methodology-8e54a67c

The Wall Street Journal set out to examine the system under which Medicare Advantage insurers can collect extra federal money for patients with certain conditions.
The Journal reviewed Medicare data under a research agreement with the federal government. The data doesn't include patients' names, but covers details of doctor visits, hospital stays, prescriptions and other care.
For years 2018 through 2021, the Journal studied Medicare Advantage patients who were enrolled in a single plan for the full year and had drug coverage through Medicare.
The analysis excluded those with advanced kidney disease, who received hospice care or who were enrolled in certain types of Medicare plans with atypical payment rules.
Those criteria yielded an average of 20 million enrollees in each year of the analysis, or about 84% of all Medicare Advantage members.
The Journal analyzed roughly two billion diagnoses that those patients received from either doctors, hospitals or their insurance companies. Next, it narrowed those diagnoses to ones listed on claims that qualify under Medicare rules to be considered for so-called risk-adjustment payments—extra payments to Medicare Advantage insurers.
Among those 1.6 billion diagnoses, the Journal determined which ones were added by insurers, either after reviewing doctors' charts or sending medical workers to do assessments in patients' homes. The Journal identified claims resulting from home assessments based on criteria used by other researchers, and counted anyone with up to two such visits.
The next steps were to figure out which diagnoses actually result in extra payments, and among those, which were due only to diagnoses added by insurers.
The Journal then matched up those diagnoses with payment categories set by Medicare, called Hierarchical Condition Categories, or HCCs. Not every diagnosis leads to a payment, and some cancel out others. Insurers, for example, can't get paid extra for a patient's depression if they already are getting paid extra for schizophrenia.
Next, for each category and patient, the Journal checked whether the related diagnoses came just from insurers or included physicians' diagnoses.
To determine how much extra money Medicare paid for the insurer-driven diagnoses, the Journal calculated payments for those HCCs using a formula published by Medicare. The formula includes a base payment amount, a geographic adjustment and some other adjustment factors.
To estimate the base payment amounts, the Journal used plan payment data that Medicare has published through 2021. The Journal estimated the geographic adjustments using public plan enrollment data and cost data published by Medicare.
The Journal used data from the system Medicare currently uses to calculate Medicare Advantage payments. During the Journal's study period, Medicare used a now mostly retired data system for some of its payment calculations, but researchers say diagnoses were consistent between the two systems.
The Journal then sought to determine whether patients with diagnoses added just by insurers received typical treatments for those conditions at the same rates as those diagnosed by their doctors. The Journal interviewed medical experts to come up with lists of prescription drugs considered standard treatments for most patients with certain diseases.
For each disease, the Journal determined whether each patient had at least one prescription filled for a recommended drug in a calendar year when they received the diagnosis. The Journal then compared the drug-treatment rates for two groups of patients: Medicare Advantage patients with diagnoses only from their insurers, and all Medicare patients who got diagnoses from their doctors.
The Journal also studied questionable diagnoses, such as for diabetic cataracts in people who had already had cataract surgery in both eyes. In that analysis, the Journal identified people for whom insurers had been billed by eye surgeons treating both their left and right eyes, but who had a diagnosis of diabetic cataracts in a calendar year after both eyes had been repaired.
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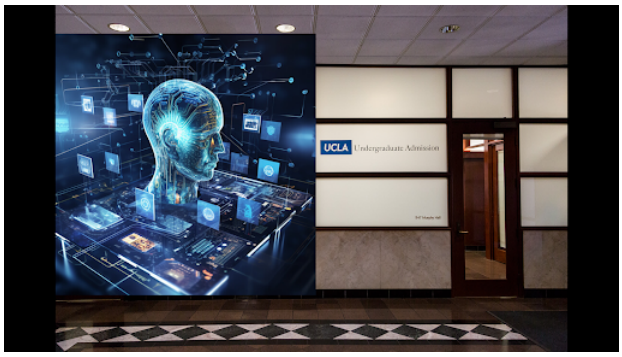
*https://uclafacultyassociation.blogspot.com/2024/06/medicare-advantage-scrutiny-continues.html.

Posted by California Policy Issues at 3:00 AM No comments:

Labels: health care, uc retirement

Tuesday, July 9, 2024

So glad that nothing like this could happen at UCLA...



...Or could it? From Inside Higher Ed:

A Lehigh University student with a full scholarship pleaded guilty to a forgery change and was expelled after admitting online that he faked admissions documents and used ChatGPT to write his essay. Aryan Anand, 19, was expelled from the private Pennsylvania university this spring after falsifying documents, including his father's death certificate, tax documents and an email address to impersonate a school principal, according to a report from the Northampton County District Attorney's Office obtained by Inside Higher Ed.

"Lehigh University revoked his status as a student and his admission was rescinded," a university spokesperson said in a statement to Inside Higher Ed. "A thorough investigation by Lehigh University police revealed significant fraudulent materials submitted for admission, leading to charges." ...

Full story at https://www.insidehighered.com/news/quick-takes/2024/07/08/student-won-scholarship-fake-documents-ai-written-essay.

If you read the full story, you will discover that the fraud was detected only when the student bragged about it on social media.

Posted by California Policy Issues at 3:30 AM No comments:

Labels: admissions, email fraud, Lehigh U

Coming Election

If you were looking for something on the November ballot that would directly aid UC, you will be disappointed. There was some talk early on about UC getting something from the education bond. However, the education bond that eventually was put on the ballot covers K-14, not UC. There could be some indirect effects of some of the upcoming propositions. The Sacramento Bee provides a summary:

Proposition 2, education facilities bond: *Prop. 2 asks voters to approve $10 billion in bond financing for aging educational facilities. If approved, $8.5 billion would go toward updating or building new K-12 buildings. The remaining $1.5 billion would be used for community colleges. It's the second time in five years voters are being asked to allow the state to take on debt for school infrastructure – voters rejected a $15 billion school bond in March 2020.*

Proposition 3, marriage equality: *This ballot measure would eliminate outdated language from California's Constitution that says marriage is a union between one man and one woman. Voters enshrined this definition, effectively banning same-sex marriages, when they approved Proposition 8 in 2008. Courts eventually struck down the decision, but the wording remains on the books. Californians will once again decide whether to change the Constitution's language this November. Assemblyman Evan Low, D-Campbell is the author behind ACA 5. The proposition arrived on the ballot after the Legislature passed the amendment with unanimous support.*

Proposition 4, climate bond: *Similar to Prop. 2, lawmakers placed Prop. 4 on the ballot to request $10 billion in bond funds for a variety of climate projects. The bond comes after two years of significant budget deficits which saw California's climate spending scaled back. If approved, $3.8 billion would go toward safe drinking water and drought and flood resilience; $1.5 billion for wildfire resilience; $1.2 billion to protect against sea level rise; and other allocations for biodiversity, outdoor access, clean air and more.*

Proposition 5, local government funding: *Prop. 5 would lower the supermajority vote required by voters to approve local special taxes for housing and infrastructure projects in California. Currently, a two-thirds vote is needed, but this constitutional amendment would lower the threshold to 55%. If passed, it would be easier for local governments to pass taxes or issue bonds to develop affordable housing in their jurisdictions. But opponents claim the measure's language is too vague and could lead to huge tax hikes on infrastructure projects that don't aid Californians.*

Proposition 6, slavery: *Prop. 6 would remove all language allowing slavery and involuntary servitude from California's constitution. Currently, the constitution reads "Slavery is prohibited. Involuntary servitude is prohibited except to punish crime." That language would be amended to read "Slavery and involuntary servitude is prohibited." It would also ban the California Department of Corrections and Rehabilitation from punishing inmates for refusing a work assignment. A companion bill created a voluntary work program in the prison system. The proposition was placed on the ballot by California lawmakers and was a priority for the legislature's Black Caucus. Its members said California is one of just 16 states that still allows involuntary servitude for incarcerated people.*

Proposition 32, minimum wage: *This ballot initiative would bump up California's minimum wage to $18 an hour over the next couple years. If it passes, all minimum wage workers who earn $16 an hour right now, would see their pay gradually increased by a dollar each year until it reaches $18 on January 1, 2026. The measure does require larger businesses with more than 25 employees to reach $18 at a faster pace, by the start of 2025. However, if an economic downturn occurs, the Governor has the power to suspend increases twice, which could delay when an $18 minimum wage actually reaches Californians.*

Proposition 33, rent control: *A vote in favor of this measure would expand rent control in California. If the proposition passes, it would get rid of a nearly three decade-old law, known as the Costa-Hawkins Rental Housing Act, that bans rent control on single-family homes finished after February 1, 1995. Cities and counties would have more power to limit rent increases for incoming and existing tenants, making it harder for landlords to hike up prices. The measure would also insert new language into California law that prohibits the state from limiting how cities and counties expand or maintain rent control. It's backed by the Aids Healthcare Foundation and is the third time since 2018 that voters will decide on the issue: Similar ballot initiatives, in 2018 and 2020, failed by 19 and 20 points, respectively.*

Proposition 34, funding for patient care: *Prop. 34 requires certain organizations that use a federal drug discount program to spend at least 98% of those funds on direct patient care. Proponents who put the measure on the ballot say it is meant to go after the Aids Healthcare Foundation, which critics accuse the nonprofit of spending millions on political causes (such as Prop 34) rather than patient care and housing. The AHF has called Prop 34 "a wolf in sheep's clothing."*

Proposition 35, permanent Medi-Cal funding: *Prop. 35 would make permanent a tax on health insurers, also known as the MCO tax, which is currently set to expire in 2026. Newsom and legislative leaders recently renewed the tax to help fill budget deficits. Implementing the MCO tax also allows the state to draw down additional federal funds to pay for Medi-Cal, the state's health care program for poor residents. The measure requires funds from the tax to be used specifically for Medi-Cal and prohibits the state from using the money to replace existing funds. The MCO tax is expected to bring in between $6 and $9 billion by the end of 2026, but analysis by the Legislative Analyst's Office said the long-term fiscal effects of the measure are uncertain.*

Proposition 36, criminal penalties: *This measure would revise Prop. 47, a 2014 ballot initiative that downsized some lower-level crimes to misdemeanors and put in place a $950 threshold for shoplifting felonies. The ballot measure's backers, which include San Francisco Mayor London Breed and the California District Attorneys Association, argue Prop. 47 has led to increased crime and retail theft. The proposed changes would raise penalties and sentences for some drug and theft offenses. For example, fentanyl would be added to the list of drugs that warrant a felony charge if the person also possesses a gun, increasing the punishment from up to one year in jail to up to four years in prison. Another major revision would hike up punishments for convicted shoplifters with two or more prior theft-related convictions. Gov. Newsom and other Democratic leaders in the legislature are opposed to Prop. 36. They have floated their own 14-bill package to reduce retail theft instead, and had been crafting their own counter-initiative to put on the ballot, before Newsom abruptly abandoned that effort on July 2.*

Full article at https://www.sacbee.com/news/politics-government/capitol-alert/article289594036.html.

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